

Key Provisions of the Affordable Care Act for the Ryan White HIV/AIDS Program

The Affordable Care Act increases access to health insurance coverage and health services for all Americans, including people living with HIV/AIDS (PLWH), through a number of private market reforms, an expansion of Medicaid eligibility, and the establishment of Health Insurance Marketplaces (also referred to as Exchanges). The federal government, states, insurers, and consumers have a number of roles and responsibilities to help with implementation of the Affordable Care Act. This brief provides an overview of the major provisions within the Affordable Care Act that benefit PLWH.

Private Insurance Market Reforms

The Affordable Care Act includes a number of private health insurance market reforms that will benefit PLWH. PLWH cannot be prevented from purchasing most private health insurance plans-- from which they historically have been excluded -- based on having HIV/AIDS as a pre-existing condition. Most reforms will be effective on January 1, 2014, although some provisions have been effective since 2010. These reforms include:

- Guaranteed availability of coverage, which prevents insurers from denying coverage to individuals based on pre-existing conditions
- Fair health insurance premiums, which prohibits discriminatory premium rates by preventing insurers from charging more for individuals based on pre-existing conditions
- Prohibition of pre-existing condition exclusions or other discrimination based on health status
- Prohibitions against imposing annual dollar limits on essential health benefits
- Dependent coverage extension (up to age 26)
- Coverage of specified preventive health services without cost-sharing

Visit http://www.healthcare.gov/law/features/rights/bill-of-rights/index.html to learn more about Affordable Care Act private market reforms.

Key Players & Some Core Responsibilities

Federal action: Monitor compliance with and enforce federal laws (except where states are primary regulators of the insurance industry and are substantially enforcing requirements)

State action: Monitor compliance with and enforce state insurance laws

Insurer action: Comply with federal and state laws

Consumer action: Understand the law and sign-up for updates by visiting HealthCare.gov

Medicaid Coverage

The Affordable Care Act establishes a new Medicaid eligibility category for low-income adults between 19-64 years of age with income at or below 133 percent of the Federal Poverty Level (FPL). If a state expands its Medicaid program, low-income people living with HIV who meet the new eligibility criteria will no longer have to wait for an AIDS diagnosis to qualify for Medicaid.

In states that implement this Medicaid expansion, eligibility will be determined using Modified Adjusted Gross Income (MAGI) based methods. If necessary for establishing income eligibility, an income disregard equal to 5 percentage points of the FPL will be applied. Under the law, the "newly eligible" individuals will be enrolled into a Medicaid Alternative Benefit Plan, which must include coverage of the ten statutory essential health benefit categories and comply with state and federal regulations.

Key Players & Some Core Responsibilities

Federal Action: CMS will provide guidance to states on Medicaid expansion, approve state plan amendments for expansion, and regulate inclusion of essential health benefits in Alternative Benefit Plans. CMS will also provide the additional Federal Matching Assistance Percentage (FMAP) for states that choose to expand their Medicaid Program.

State Action: If a state implements Medicaid expansion, it is responsible for establishing Medicaid Alternative Benefit plans for "new eligible" individuals, which must include coverage of essential health benefits. Regardless of its expansion decision, a state must determine income using a Modified Adjusted Gross Income (MAGI) based methodology for non-elderly, non-disabled eligibility groups (except for groups whose eligibility is based on medical need or on receipt of Medicare) covered in each state. States are also responsible for developing a transition strategy and coordinating with the Health Insurance Marketplace in their state.

Health Provider Action: In states that choose to expand and use a managed care model, providers should consider negotiating and contracting with Medicaid managed care plans to ensure alignment with payer of last resort policy.

Consumer Action: Consumers should learn if their state is expanding its Medicaid program and whether they are eligible. If enrolled in a Medicaid managed care plan, the consumer should make sure he/she selects a primary care provider.

Health Insurance Marketplaces

Starting January 2014, PLWH with incomes between 100-400% FPL who are not eligible for other affordable insurance through an employer or other government program may be eligible for federal premium tax credits and/or cost sharing reductions to help pay for private health insurance—specifically qualified health plans—through a Health Insurance Marketplace (or Exchange).

Individuals between 100%-400% FPL may be eligible for premium tax credits distributed on a sliding-income scale and based on the premium of the second lowest cost silver plan offered in a state's Health Insurance Marketplace. Individuals between 100%-250% FPL may also be eligible for cost-sharing reductions if they enroll in a silver level plan. Indians are eligible for additional cost-sharing reductions if their household income is below 300% FPL or for services and items provided by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization, or through referral under contract health services. Other eligibility requirements for this assistance and subsidies apply. To learn more about premium tax credits, visit http://www.healthcare.gov/marketplace/costs/tax-credits/index.html.

Health Insurance Marketplaces are designed to make buying health insurance coverage in the individual and small group market easier and more affordable. These Marketplaces will provide a "one-stop shop" for individuals to compare qualified health plan options, get answers to health coverage questions, find out if they are eligible for affordability programs like Medicaid and CHIP or premium tax credits to purchase private insurance, and enroll in a qualified health plan that meets their individual needs. Visit http://www.healthcare.gov/marketplace/index.html to learn more about Health Insurance Marketplaces.

States can choose to operate their own Health Insurance Marketplace (State-based Marketplace), participate in one in partnership with HHS (State Partnership Marketplace), or allow HHS to manage and operate a Federally-facilitated Marketplace. Visit http://cciio.cms.gov/resources/factsheets/state-marketplaces.html to learn more about what type of Health Insurance Marketplace may be operating in your state.

Key Players & Some Core Responsibilities

Federal Action: HHS approves operating plans for states that choose to establish their own State-based Marketplace. A State Partnership Marketplace enables states to assume primary responsibility for carrying out certain activities related to plan management, consumer assistance and outreach, or both. HHS will carry out all minimum Marketplace functions not performed by states in the State Partnership Marketplace and will oversee operation of the entire Marketplace. In states that do not have a State-based Marketplace or a State Partnership Marketplace, HHS will be responsible for certifying qualified health plans and establishing and monitoring compliance with network adequacy standards and essential community provider requirements. HHS will also administer, oversee, and support in-person application assistance to consumers, including a Navigator Program in Federally-facilitated or State Partnership Marketplaces to assist consumers in understanding their health insurance options and enrolling in a health plan.

State Action: States must decide whether to establish a State-based Marketplace, State Partnership Marketplace, or rely on a Federally-facilitated Marketplace. The deadline for notifying HHS of establishing a State-based Marketplace passed on December 14, 2012. States had until February 15, 2013 to notify HHS and submit an application to participate in a State Partnership Exchange, or cooperate in other ways with HHS with respect to a Marketplace in their State. States operating State-based Marketplaces are responsible for the following: approving and contracting with accredited qualified health plans for State-based Marketplaces

and ensuring they comply with non-discrimination standards and EHB requirements; establishing and monitoring compliance with network adequacy standards and essential community provider requirements for State-based Marketplaces; developing a streamlined eligibility and enrollment process to assess and enroll individuals into Medicaid or the Marketplace and develop a transition strategy for moving individuals from the Pre-Existing Condition Insurance Plan to a qualified health plan in the Marketplace; and administering, overseeing, and supporting in-person application assistance, including a Navigator Program. In states that choose to carry out consumer assistance activities as a partner in a State Partnership Marketplace, the states will support the Navigator program as well as administer and support other in-person assistance programs.

Insurer Action: Insurers may choose to offer coverage--their qualified health plans--through the Marketplaces. They must ensure all health plans offered through the Marketplaces meet qualified health plan standards, including network adequacy standards and inclusion of a sufficient number of essential community providers, as well as other qualified health plan standards. Insurers may choose to market their qualified health plans.

Health Provider Action: Health providers should consider contracting with health plans to ensure they will be included in networks by January 1, 2014 to ensure alignment with payer of last resort policy.

Consumer Action: Initial open enrollment for the Marketplaces begins on October 1, 2013 and ends on March 31, 2014. Consumers should apply before December 15, 2013 to ensure that their new qualified health coverage begins on January 1, 2014. Utilizing consumer assistance programs, such as Navigators, can help consumers understand their Marketplace health plan options. Consumers should also visit http://www.healthcare.gov/marketplace/get-ready/index.html to learn about more ways to prepare for enrollment in the Health Insurance Marketplace.

Essential Health Benefits

PLWH who obtain insurance through non-grandfathered health plans (inside or outside Health Insurance Marketplaces) or through Medicaid in a Medicaid Alternative Benefit Plan will be ensured coverage of "essential health benefits" (EHB). With respect to plan years (small group market) and policy years (individual market) beginning on or after January 1, 2014, non-grandfathered health plans offered in the individual and small group markets (inside and outside the Health Insurance Marketplaces) and Medicaid Alternative Benefit Plans must offer a core package of items and services known as the "essential health benefits" (EHB). EHB must include items and services within at least the following ten categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

On November 20, 2012, the Center for Medicaid and CHIP services (CMCS) released a letter to State Medicaid Directors to provide guidance to states on the use of Alternative Benefit Plans for

the new eligibility group of low-income adults and the relationship between Alternative Benefit Plans and EHB. ¹ CMCS also issued a proposed rule on January 14, 2013 outlining EHB coverage requirements in Medicaid. ²

A final rule issued in February 2013 outlines health insurance issuer standards for EHB that non-grandfathered individual and small group health insurance issuers must cover both inside and outside the Health Insurance Marketplace.³ The Affordable Care Act requires that the scope of the EHB be equal to the scope of benefits offered in a "typical employer plan." To give states the flexibility to define EHB in a way that would best meet the needs of their residents, this rule finalizes a benchmark-based approach. This approach allows states to select a benchmark plan from options offered in the market. If a base-benchmark plan does not cover any benefits in any of the ten required categories of EHB, the base-benchmark plan must be supplemented by adding the entire category of benefits from another of the benchmark plan options to establish the EHB-benchmark plan for that state. Twenty-six states selected a benchmark plan for their state. In the other states and Puerto Rico, the largest small group market plan by enrollment in each state will be the base-benchmark and in the other U.S. territories, the largest Federal Employee Health Benefit Plan by enrollment will be the base-benchmark.⁴ To learn more about a state's EHB-benchmark plan selection, please visit http://cciio.cms.gov/resources/data/ehb.html.

Beginning in 2014, plans that are required to cover EHB also must cover a certain percentage of the total allowed costs of providing benefits, known as actuarial value or "metal levels." These levels are 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Metal levels will allow consumers to compare insurance plans with similar levels of coverage and cost-sharing based on premiums, provider networks, and other factors.

Further, a health plan is not deemed to provide EHB unless it covers at least one drug in every United States Pharmacopeia (USP) category and class, or the same number of prescription drugs in every category and class as the EHB benchmark plan, whichever is greater. Health plans must also have procedures in place to allow enrollees to request and gain access to clinically appropriate drugs not covered by the health plan.

Visit http://cciio.cms.gov/resources/factsheets/ehb-2-20-2013.html to learn more about the EHB final regulation for non-grandfathered individual and small group market plans.

¹ See http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf

² See http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf

³ See http://www.ofr.gov/OFRUpload/OFRData/2013-04084 PI.pdf

⁴ Appendix A of the final EHB regulation includes the final list of EHB-benchmark plan for coverage years in 2014 and 2015. *See* http://www.ofr.gov/OFRUpload/OFRData/2013-04084 PI.pdf.

Key Players & Some Core Responsibilities

Federal action: HHS defined essential health benefits based on a benchmark plan selected by each State. HHS reviews proposed benchmark plan selections submitted by states to ensure compliance with federal law and non-discrimination standards.

State action: States select a benchmark plan for the individual and small group market (both inside and outside the Health Insurance Marketplace) that defines EHB and ensure benchmark plans contain all required benefits and otherwise comply with federal law. States must also ensure that Medicaid Alternative Benefit Plans include coverage of EHB as outlined in the federal regulation.

Insurer action: Under the final rule, non-grandfathered insurers in the individual and small group market must include coverage of EHB using the EHB-benchmark plan as a reference plan. Insurers may set different limitations on coverage so long as they remain substantially equal to the state's benchmark plan and would be subject to review pursuant to statutory prohibitions on discrimination in benefit design. Health plans must also comply with prescription drug formulary minimum requirements as outlined in the final rule.

Consumer action: Although non-grandfathered health plans in the individual and small group market are required to cover EHB, insurers' benefit design may vary. Consumers should review plans' benefits when selecting a health plan.